MEDICARE CONTRACTING FOR ADMINISTRATIVE SERVICES: COMPETITIVE ALTERNATIVES

Staff Memorandum

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This analysis was prepared by Darrell Hollonbeck of the Human Resources and Community Development Division of the Congressional Budget Office, under the supervision of Nancy M. Gordon and Paul B. Ginsburg. The study was essentially complete as of April 1983, but was delayed by Mr. Hollonbeck's extended illness. In order to avoid further delay, the study is being released now without updating. Please bear in mind that the text and numbers are correct only as of April 1983. Questions regarding the analysis may be addressed to Nancy Gordon on 226-2669.

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SUMMARY

In fiscal year 1983, Medicare contractors are expected to process 280 million claims and provide reimbursement for benefit payments totaling more than $56 billion. The federal government uses contractors to perform four types of activities:

- Process claims promptly and accurately;
- Design and implement claims review procedures to ensure that payment is provided only for reasonable and necessary medical services;
- Maintain good relations with the health-care provider and beneficiary communities; and
- Adjudicate beneficiary appeals arising from insufficient reimbursement or denial.

Medicare will pay approximately $800 million, or 1.4 percent of total program costs, for these services.

BACKGROUND

When Medicare was enacted, profit and nonprofit health insurance corporations were selected by local providers of health-care services to serve as Health Insurance (HI) contractors--known as intermediaries--and Supplemental Medical Insurance (SMI) contractors--known as carriers. When more than one contractor has been approved for a local area, individual providers can chose among them.

Contractors are generally reimbursed for all costs associated with their Medicare activities. In fiscal year 1982, however, an unusually tight appropriation led the Health Care Financing Administration (HCFA) to reimburse contractors for only part of the expenses above budgets negotiated at the beginning of the year.

Theoretically, cost reimbursement perpetuates insufficient and ineffective management practices. Under such a payment system, contractors are not encouraged financially to implement cost-efficient managerial practices. Indeed, in some circumstances, the system encourages contractors to shift expenses from their private business to Medicare. Differences in managerial efficiency across contractors contribute, in part, to variations in the average cost of processing a claim (unit costs). In fiscal year 1982, HI claims processing costs varied between $2.79 and $7.35 per claim; SMI unit costs varied between $1.91 and $3.92. Some contend that the recent departure from cost reimbursement that has been forced by budget stringency has increased efficiency significantly, however.

Another criticism of the current system is that the method used to evaluate contractors' performance may overemphasize low administrative costs and exclude other activities designed to limit the total benefits paid by the program. In effect, small reductions in administrative costs may be achieved at a much larger cost for benefits that should not be reimbursed by

Medicare, since too few resources may be devoted to medical utilization reviews and other costly activities that reduce payments for unnecessary or duplicative services. While the evaluation system used to measure contractors' performance examines these so called "benefit-safeguard" activities, this assessment focuses primarily on the existence rather than the effectiveness of these activities. As a result, contractors differ considerably in the resources they devote to ensuring accurate benefit payments.

COMPETITION AND THE FIXED-PRICE CONTRACT

The competitive award of Medicare administrative contracts, used in conjunction with a fixed-price contract, has been proposed as a mechanism to encourage cost-efficient management by contractors. The introduction of market forces in awarding contracts could force competitors to adopt managerial improvements that would increase efficiency and could reduce outlays for Medicare's administration.

Because Medicare's administrative costs constitute only 1.4 percent of total program costs, however, such a reduction in administrative costs might not significantly reduce total Medicare outlays. Attention focused exclusively on administrative costs could encourage contractors to reduce resources for benefit safeguard activities and for those activities that provide a high level of service to the beneficiary and provider communities. In addition, the quality, accuracy, and promptness with which claims are

processed could be reduced during the transition to contractors winning the competitively awarded contracts.

Under demonstration authority, HCFA has implemented seven competitively awarded, fixed-price contracts. Valuable information was obtained from these experiments with which to assess the impact of competition on several aspects of the Medicare program:

- o Administrative costs,
- o Total benefit payments, and
- o The promptness of claims processing.

These effects are discussed in the following sections.

Administrative Costs

When several competitors participated in the contract solicitation, Medicare payments to contractors were reduced by approximately 10 percent relative to the projected costs of continuing with the incumbent cost-reimbursement contractor. In solicitations that drew few bidders, however, bids were considerably higher than the projected costs of the incumbent contractor and, in one competition, the solicitation was withdrawn because of the high price of the only bid.

Recent solicitations have produced few competitors, clouding the otherwise significant potential of competition to reduce administrative

costs. This reluctance to bid on the part of potential contractors may reflect the recent uncertainties about the cost-reimbursement system--under which some costs have not actually been reimbursed. In essence, contractors may see small potential gains and large potential losses associated with the fixed-price contract.

Benefit Payments

The impact of competition on total benefit payments is unclear, since in the three states where data are available the differences between amounts paid under the demonstration projects and those projected under the previous system varied considerably. Moreover, cost data submitted by fixed-price contractors were insufficiently detailed to determine if the level of resources expended for benefit-safeguard activities affected the level of benefit payments or if this variation resulted from other factors. This issue remains a primary concern with the fixed-price contract for, as discussed, the differential allocation of resources for benefit safeguards could easily more than offset any administrative efficiencies induced by competition.

Another discouraging finding is that fixed-price contractors consistently and significantly increased the rate of erroneous payments and, because overpayments exceeded underpayments, expenditures increased unnecessarily. This inaccuracy may also have affected numerous individual beneficiaries who may have had to absorb underpayments made by the contractor.

Timeliness of Claims Processing

Contractors were, in most circumstances, able to maintain the promptness with which claims were processed by incumbents. In the one situation, the average processing time doubled, however, creating massive dissatisfaction and complaints among providers and beneficiaries.

OPTIONS

This report analyzes three options to modify the existing system for the award of Medicare contractors. The discussion is limited to SMI contractors because of the current lack of data from the HI demonstration projections. The first alternative would use competition to select all contractors and reimburse them through fixed-price contracts. The second would substitute competition only to replace contractors with high administrative costs and also use fixed-price contracts. The third option would use competition cost-reimbursement contracts to replace those contractors with repeatedly high levels of erroneous benefit payments or with ineffective procedures to safeguard benefit payments. The budget impact of each alternative for fiscal years 1984 to 1988 is shown in Summary Table 1.

SUMMARY TABLE 1. BUDGET IMPACT OF COMPETITIVE OPTIONS, FISCAL YEARS 1984-1988 (In millions of dollars)

	Alternative 1 a/	Alternative 2 b/	Alternative 3 c/
Administrative Costs	270	-30	130
Benefit Payments	390	150	-370
Total	660	120	-240

SOURCE: Preliminary CBO estimates.

NOTE: Positive sign denotes increased expenditures.

a. Competition to award all contracts (using fixed-price reimbursement).

b. Competition to replace high-cost contractors (using fixed-price reimbursement).

c. Competition to replace contractors performing poorly on benefit-safeguard activities (using cost reimbursement).

Competition to Award All Contracts (Using Fixed-Price Reimbursement)

This option would award all Medicare contracts on the basis of competitive procurement. Contractors would be reimbursed at a rate based on a fixed price for a designated period of time or for some predefined unit of work determined at the time of contract award. The transition to competitively awarded, fixed-price contracts would occur over four years beginning with fiscal year 1984.

Under this alternative, total program costs would increase by $40 million in fiscal year 1984 and by $660 million over the period of fiscal years 1984 to 1988. Administrative costs would account for $270 million of the five-year rise. Although competition theoretically would reduce program administrative costs relative to the cost-reimbursement system, the limited interest in competition among potential bidders, the small savings obtainable from those contractors that are currently performing efficiently, and the significant transition costs would actually raise them.

Benefit payments would also increase--by $390 million over the period--because of increased error rates. Higher error rates would raise outlays since overpayments tend to exceed underpayments. This estimate assumes that the results of claims review would be about the same as under current law, because fixed-price contractors would devote roughly the same levels of resources to benefit safeguard activities. (This assumption is consistent with the mixed claims-review experience of the demonstration projects.)

Moreover, the implementation of the competitive fixed-price contract would require 14 SMI solicitations per year; the continual monitoring and technical assistance necessary to maintain the functioning of the overall system would tax the oversight capabilities of HCFA, unless central and regional staff were increased substantially. Lastly, this option would disrupt the contractors' operations for three quarters.

Competition to Replace High-Cost Contractors (Using Fixed-Price Reimbursement)

In contrast to the first alternative, the second would limit competition to those territories currently served by contractors with consistently high administrative costs. The selective use of competition is intended to replace high-cost performers while minimizing the potentially disruptive and costly effects of competition on contractors' performance.

This alternative would increase total program costs by $20 million in fiscal year 1984, during which the initial solicitations would be awarded and transition activities would occur. Over the period 1984 to 1988, this alternative would raise total program outlays by $120 million--the net effect of lower administrative costs but higher benefit payments.

The option would reduce administrative costs by $30 million over the five years when 14 contracts would be awarded competitively. These savings are limited, in part, by the large transition costs associated with the establishment of facilities and operations in the new territory. Consequently, savings might be expected to increase in future years. Since incumbent cost-reimbursement contractors with low administrative costs would be retained, they would have incentives to invest in new technologies and other cost-efficient management strategies in order to achieve future efficiencies and avoid competition for their contracts.

Benefit payments would increase by $150 million between fiscal years 1984 and 1988, because of higher error rates, however. As in the first option, fixed-price contractors are assumed to continue roughly the same levels of benefit safeguard activities as their cost-reimbursement predecessors. In spite of these activities, erroneous benefit payments would rise more than offsetting the administrative savings realized by the selective application of competition.

Competition to Replace Contractors Performing Poorly on Benefit-Safeguard Activities (Using Cost Reimbursement)

This alternative would introduce competition in the award of Medicare administrative contracts to eliminate those who perform poorly on benefit safeguard activities. Contractors would be replaced by competitors with the demonstrated capabilities to implement innovative and cost-efficient activities designed to improve the accuracy of benefit payments to eligible individuals. Performance on the payment-deductible error rate or some other measure that objectively embodies this payment-safeguard orientation would serve as the most important selection criterion. As under the current system, the contractor would be reimbursed for the actual costs of performing administrative activities.

In fiscal year 1984, this option would save $7 million; between fiscal years 1984 and 1988, total program outlays would be reduced by $240 million. The higher level of safeguard activities would reduce benefit

payments by $370 million over the five-year period, but raise administrative costs by $130 million. Some uncertainty is associated with the estimate of benefit payment reductions, however. While the General Accounting Office (GAO) has estimated that benefit safeguard activities return $7 for each $1 spent, it is not known at what point diminishing returns would set in.

This approach would have the additional advantage that it would serve as a stimulus for all contractors to implement effective benefit reduction activities in order to avoid the competitive process. This effect is not, however, included in the estimate of federal savings.

CHAPTER I. INTRODUCTION AND OVERVIEW

The Medicare program contracts with private health insurance organizations to perform activities related to the payment of benefits. These contractors establish rates of reimbursement, verify program eligibility, establish medical necessity, and reimburse claimants for medical expenses. At the inception of Medicare in 1966, contractors were nominated by local provider organizations and approved by the Health Care Financing Administration (HCFA)--the federal agency responsible for administration of the program. This nomination process resulted primarily in the selection of Blue Cross and Blue Shield affiliate organizations. Reimbursements for administrative services are expected to exceed $800 million in fiscal year 1983.

Contractors are reimbursed for all costs associated with the administration of the program within annual budgets negotiated with HCFA. Each contractor submits an annual budget based on HCFA's projections of the claims volume within the contracting district. In submitting this budget, the contractor retains discretion over the managerial practices and assumptions that are used to perform the claims processing and associated services. Should actual costs exceed the negotiated budget, the contractor can request supplemental funding and, pending HCFA approval, receive reimbursement for these expenses. In fiscal year 1982, however, contractors were not fully reimbursed for expenses incurred above the negotiated budget because of HCFA's financial constraints.

The current system is thought to perpetuate costly and ineffective management practices. By reimbursing contractors for costs incurred, it fails to create incentives for contractors to execute their administrative functions as efficiently as possible. Moreover, the administrative discretion afforded contractors in establishing annual budgets may thwart HCFA's efforts to eliminate inefficient practices and to reduce the program's administrative costs.

In addition, there is concern that the dearth of incentives to implement utilization review and other activities that ensure payment only for reasonable and necessary medical services may cause Medicare benefit expenditures to be higher than necessary. Coupled with recent reductions in the growth of administrative funds, the emphasis on low administrative costs in assessing contractor performance may seriously affect the ability of, and incentives for, contractors to implement costly procedures designed to avoid erroneous expenditures for benefits. Although these procedures are more expensive than other administrative functions, the savings in correct benefit payments should far more than outweigh their costs.

Competition in the selection of contractors has been proposed as a mechanism to induce greater efficiency in the delivery of administrative services while maintaining or improving performance. Competition could be implemented in conjunction with a fixed-price contract, under which the contractor would be reimbursed for a predetermined sum of money based on

a fixed period of time or a fixed unit of work. This contract form could reduce administrative costs by introducing market forces into the selection of contractors and the profit motive into the contractors' operations. Alternatively, a negotiated cost-reimbursement contract, such as used now, could be retained in a competitive setting. Competition could also be implemented in concert with strategies such as consolidating territories or combining administrative responsibility for the two parts of Medicare--Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)--to eliminate duplicative activities and reduce administrative costs.

Three competitive options are analyzed here:

- Competition in the award of all contracts, with reimbursement on a fixed-price basis.
- Competition used only to replace high-cost contractors, with reimbursement on a fixed-price basis.
- Competition used only to replace poor performers on benefit safeguard or operational performance measures, with reimbursement on a negotiated cost-reimbursement basis.

Chapter II provides background information on program administrative costs and discusses the concerns with the existing system. Chapter III describes the perceived advantages of competition and its likely effects on administrative costs, operational performance, and level of expenditures for benefits. The results of several competitive fixed-price demonstration projects are also reviewed. Chapter IV discusses three specific options.

CHAPTER II. THE CURRENT PROGRAM

The Medicare administrative system, relatively unchanged since the inception of the program, has important implications for the cost of the program. Direct outlays for outside contracts for administrative services will exceed $800 million in fiscal year 1983; moreover, the claims processing activities performed by these contractors influences the amount spent for Medicare benefits--expected to be about $57 billion in 1983.

The first section of this chapter describes the current system used to purchase claims processing and associated administrative services. The next section discusses the costs associated with Medicare administration. The last section examines concerns with performance under the existing system.

THE ADMINISTRATION OF THE MEDICARE PROGRAM

The Medicare program contracts with private health insurers to perform all activities related to the payment of benefits. Medicare Health Insurance (HI or Medicare Part A) contractors--called intermediaries--process claims for hospital and other institutional health-care services and determine the amount of reasonable and necessary costs to be reimbursed by Medicare. Medicare Supplemental Medical Insurance (SMI or Medicare Part B) contractors--called carriers--process and reimburse claims for medical

services performed by physicians and other health professionals, verify program eligibility, adjudicate appeals, and establish reasonable and customary charges for reimbursement. 1/ Medicare contractors are currently either Blue Cross and Blue Shield organizations or commercial health insurers. In some circumstances, health insurers subcontract with data processing firms for some claims-processing functions.

The use of contractors in the Medicare program was initiated to expedite the development of a system to distribute benefits. This system was designed to process and provide payment for the large volume of claims that was expected at program implementation, to obtain managerial and technological experience and expertise, to maximize the cooperation and involvement of the provider community in the program, and to control administrative costs. Large numbers of organizations were selected to function as intermediaries and carriers to ensure the smooth operation of the program at its inception, to reflect regional and within-state differences in the practice of medicine, and to provide ample numbers of contractors so that, over time, contractors with high administrative costs or poor performance could be replaced, thereby providing the highest quality of service.

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1. There are currently 74 HI intermediaries and 40 SMI carriers. Some individual contractors, most frequently the commercial health insurance corporations, serve multiple states or multiple partial-state areas.

One of the contractors' major responsibilities is to limit payment to reasonable and necessary services and to prevent program fraud and abuse--often referred to as benefit-safeguard activities. Through hospital audits, HI contractors verify that costs allocated to Medicare are derived from the provision of services to Medicare patients. Similarly, SMI contractors conduct a review of claims to establish the medical necessity of an individual claim and to identify potentially abusive patterns of practice.

Medicare contractors are reimbursed for all expenses incurred in the administration of the program within annual budgets negotiated with HCFA. Each annual budget is negotiated on the basis of a HCFA estimate of the work for the year derived from a projection of the claims volume, the purchase of new technologies or systems to improve efficiency (productivity enhancements), other systemic or administrative changes desired by HCFA, and the expected rate of inflation.

If the actual costs are larger than the negotiated budget because of inaccurate estimates of volume, changes in Medicare legislation affecting contractor work or responsibilities, postage increases, or other additional expenses, contractors can request supplemental funding. They receive reimbursement for costs in excess of the negotiated budget, if funds are available. As discussed in the next chapter, fiscal year 1982 represented the first year in which contractors were not reimbursed for all costs in excess of their negotiated budgets. Budgeted funds not used are returned to HCFA.

Although HCFA must approve each contractor's budget, the contractor has considerable discretion in the administration of the program, thereby creating potential differences in administrative efficiency. The internal managerial assumptions that underlie the budget submission are determined by the contractor. Without direct control over these assumptions and the resultant management practices, HCFA may be relatively powerless to eliminate administrative costs it believes to be excessive.

Contractors are audited periodically using federally defined Generally Accepted Accounting Procedures (GAAP). The audit verifies that contractor costs are attributable to Medicare activities. Medicare activities, which are distinct from private business activities, are directly charged to Medicare. Costs for activities that are shared with private business activities are allocated according to approved accounting procedures. Allocated costs may include items such as space, utilities, personnel hiring and training, retirement pensions, senior staff and other management time, computer hardware, or use of computer time.

THE COST OF MEDICARE ADMINISTRATION

The total cost of Medicare administration was $1.2 billion in fiscal year 1982. These costs are divisible into three distinct categories and functions:

- HCFA central office and regional office costs for program oversight—$160 million;

- Social Security Administration (SSA) costs for individual eligibility determination, data storage, and data processing--$370 million; and
- Contractor costs for program administration and implementation--$711 million. 2/

Throughout this paper, "Medicare administrative costs" refers exclusively to contracted services.

Currently, Medicare administrative expenses constitute 0.69 percent and 3.15 percent of the HI and SMI program costs, respectively. As a share of total costs, both rates have been decreasing over the last decade, during which expenditures for benefits increased rapidly relative to the growth in administrative costs. 3/

Although costs for Medicare administrative services have increased, on average, more than 13 percent annually since 1973, the total cost of administering the program has increased only slightly when adjusted for inflation. In fiscal year 1973, contractor costs were $308 million; expressed in 1982 dollars, they were $612 million, compared to actual costs in 1982 of $711 million. This represents a real growth rate of 1.6 percent over the ten-year period.

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2. Funds for contracted administrative activities are appropriated from the HI and SMI trust funds by the Congress as part of the Department of Health and Human Services discretionary budget.

3. Between fiscal years 1973 and 1982, administrative costs increased 130 percent, whereas expenditures for benefits increased 444 percent.

During this decade of almost constant real administrative costs, the number of HI and SMI claims increased by 142 percent and 227 percent, respectively, so that the cost per claim (unit cost) decreased dramatically (see Table 1). Claims-processing costs dropped from $4.82 to $3.03 per claim for HI contractors and from $3.23 to $2.10 for SMI contractors. Adjusted for inflation, the unit cost in 1982 was less than one-third the cost in 1973 for both HI and SMI contractors.

This reduction in unit cost is attributable primarily to the automation of the claims-processing activities, and is likely to continue. New technologies, such as the electronic submission of claims, direct electronic payment to physician and hospital accounts, and telephonic transmission of beneficiary deductible and coinsurance status, will further reduce the need for manual labor in claims processing.

The reduction in administrative unit costs also reflects the economies of scale that have been achieved through increasing the number of claims processed by each contractor. Given the existence of a functioning system, each additional (marginal) claim processed should be cheaper than those proceeding it, within limits. In some cases, these economies of scale have been realized through the consolidation of territories and the reduction of the number of contractors. 4/

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4. HCFA has been moving toward the establishment of one HI and one SMI contractor per state. HCFA is also experimenting with the integration of HI and SMI administrative responsibilities in one comprehensive contract.

TABLE 1. MEDICARE ADMINISTRATIVE COSTS PER CLAIM (By fiscal year, in dollars)

Fiscal Year	Health Insurance (Medicare Part A)	Supplemental Medical Insurance (Medicare Part B)
1973	4.82	3.23
1974	4.83	3.23
1975	4.72	3.21
1976	4.29	3.12
1977	4.57	2.98
1978	4.08	2.86
1979	4.07	2.82
1980	4.17	2.74
1981	3.86	2.67
1982	3.03	2.10

Because of budgetary restraints in fiscal year 1982, the Congressional appropriation for contractor expenses was inadequate to meet program administrative responsibilities. HCFA responded in four ways. First, it released administrative contingency funds and diverted funds from benefit-

safeguard activities to claims processing and other legally required activities. 5/ Second, it reviewed contractor administrative responsibilities and relaxed many processing and beneficiary service requirements. 6/ Third, it directed contractors to identify and implement methods to improve management efficiency. Finally, HCFA reimbursed contractors 90 cents for each one dollar of expenses incurred above their negotiated budget. 7/

The fiscal year 1982 funding shortage demonstrated that contractors could no longer be guaranteed that they would be reimbursed for all incurred costs. As a result of the limitation on administrative funds, contractors suggest that managerial efficiencies were forced into the system, but they also argue that no further efficiencies are possible. In their view, further reductions in administrative costs, whether achieved under a negotiated cost-reimbursement or a competitive fixed-price contract, would seriously affect the quality and timeliness of services provided and cause serious reductions in benefit-safeguard activities, increasing benefit expenditures.

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5. In order to prevent reductions in benefit-safeguard activities in future years, the Congress responded by appropriating an additional $45 million for HI and SMI benefit safeguards for fiscal year 1983 and for each succeeding year until 1986.

6. These program standard changes, called the Medicare Administrative Reform Initiatives (MARI), were estimated by HCFA to save $63 million in fiscal year 1982. Additional savings should be realized in future years, but amounts are not known.

7. This policy may have contradicted Medicare legislative authority that requires contractor reimbursement for costs, but it was necessary because of the appropriated ceiling on contractor expenditures.

Others believe that the limitation of administrative funds resulted in relaxed performance standards rather than managerial efficiency on the part of contractors. They maintain that until contractors are more directly financially responsible for operations, managerial inefficiencies will be continued.

PROBLEMS WITH THE CURRENT SYSTEM

Critics identify several weaknesses in the current contractor system, including, among others, the lack of incentives for cost-effective management and for implementation of policies that realize technological and economic efficiencies, the potentially high costs derived from the allocation methods used to determine rates of administrative reimbursement, and the limited incentives for contractors to expand activities designed to limit payment to services that are medically necessary.

Costly Management Practices

The system of cost reimbursement lacks incentives for cost-effective management and may thereby perpetuate expensive, inefficient management practices. Once chosen, a contractor is virtually guaranteed to continue indefinitely the role of carrier or intermediary.

Although overall Medicare unit costs have been decreasing steadily, there appears to be considerable variation in the management efficiencies

of individual contractors. These differences are partly reflected in differences in the unit cost of claims processing. For example, in fiscal year 1981, HI contractors' costs for claims-processing activities ranged between $2.79 and $7.35 per claim. 8/ SMI contractors ranged between $1.91 and $3.92 per claim. These differences remain, even after estimated economies of scale are taken into account.

This measurement of contractor performance may be insufficiently specific to identify whether management is efficient, however. Besides economies of scale, cost per claim is sensitive to factors such as assignment rates, provider or beneficiary mix, unexpected fluctuations in claims volumes, differential expenditures for benefit-safeguard activities, and the purchase of systems or technologies by individual contractors to streamline operations, all of which may mask the effects of good or bad management.

Costly Allocation Procedures

Medicare's cost-allocation procedures may result in payments to contractors that are too high. These procedures distribute corporate expenses among the various business "products" and, in doing so, ensure that each product absorbs its portion of corporate expenses for accounting, tax, and pricing purposes.

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8. The HI values exclude audit activities. If audit costs are included, HI unit costs range from $3.66 to $8.80.

Medicare may be absorbing disproportionately high levels of corporate expense for space and pension plans, in particular. The charge to Medicare for space can be determined using an average cost per foot for all corporate-owned and rented space. Expenses for new corporate skyscrappers, headquarters, or other space can be included in this computation which, in general, could produce a space rental cost higher than the cost of renting the actual space used for Medicare activities. Similarly, wage differences and the low probability that Medicare workers will continue employment with the contractor until they retire, relative to workers in other lines of corporate businesses, may create larger contributions by Medicare to corporate pension plans than necessary to provide retirement benefits for processors of Medicare claims.

Structural Economic Inefficiencies

Program administrators have been criticized for their reluctance to use existing legislative authority to consolidate territories or employ other structural modifications to reduce program administrative costs and improve program management. The consolidation of territories to achieve greater cost efficiencies was pursued only after frequent criticism by outside groups. Critics suggest that another structural change, the movement from costly central city processing to less costly rural localities, has not been implemented because the contractor and health-care provider communities have often criticized HCFA for such relocations in the past.

Possibly Excessive Benefit Payments

Expenditures for Medicare benefits may be higher than necessary because of the incentive in the contractor performance system for rapid processing times and low claims processing costs. These incentives discourage the establishment of effective systems and procedures to ensure that benefits are paid only as current law intends. 9/ The computation of a unit cost to assess contractor performance includes costs for both claims processing and benefit-safeguard functions and is considered heavily in the assessment of contractor performance. In contrast, performance evaluations place little emphasis on the effectiveness of the benefit-safeguard activities. The assessment criteria merely note whether the required processes are in place.

Studies indicate that the limited emphasis on benefit safeguards in the evaluation system leads to less attention to reducing Medicare expenditures. The General Accounting Office (GAO) has testified that the use of prepayment utilization reviews are particularly effective in reducing benefit payments. These reviews are conducted before payments are made to providers to assess the appropriateness of a claim relative to individual medical and claims history. It is estimated that while such reviews reduce

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9. Benefit-safeguard activities for HI and SMI constituted 23 percent and 4 percent of administrative costs, respectively, in fiscal year 1982.

benefits by $7 for each one dollar expended, 10/ they appear to be underused and are implemented unevenly. A forthcoming study by Abt Associates also concludes that additional allocation of resources for reviews reduces benefit expenditures. 11/ This finding suggests that if contractors devoted additional resources to benefit safeguards, expenditures for benefits by the federal government would be substantially reduced.

Possible Conflict of Interest

A conflict of interest may exist for many contractors whose own business operations are intimately involved in the Medicare program. Hospital expenses disallowed by Medicare are frequently borne by other third-party payers. Contractors interested in their own financial viability as private health insurers may directly or indirectly encourage the allocation of hospital costs toward Medicare, thereby raising Medicare payments and lowering their own.

Exclusion of Data Processing Firms as Prime Contractors

The legislative restriction that Medicare contractors be nonprofit or commercial health insurance organizations excludes the use of other firms,

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10. Testimony by Gregory Ahart, Director, Human Resources Division, General Accounting Office, June 15, 1982, before the Subcommittee on Health, Committee on Ways and Means, House of Representatives.

11. This analysis used six years of data to compare contractors with each other and to compare the same contractor over six years. An estimate of the relationship between expenditures for benefit safeguards and benefit expenditures is available in the final report which is expected later in 1983.

such as data processors, as Medicare prime contractors. This restriction was imposed because of the perceived importance of the skills and experience necessary to maintain beneficiary and provider relations, to conduct hospital audits, and to review claims for medical necessity.

As claims processing becomes an increasingly automated procedure, data processing firms may become more important in the design and implementation of new systems to reduce administrative costs. Although the data processing industry is expanding its role in the processing of claims for Medicare, this involvement is limited to subcontracts. Their exclusion as prime contractors may add unnecessary administrative costs because an additional firm must act as an intermediary between the government and the data processing firms.

Sluggish Technological Advancement

The current cost-reimbursement system may slow the adoption of technological advancements, because of the need for HCFA to finance the design and implementation of new systems or other productivity enhancements. Critics have charged that HCFA has been slow to finance improved methods of claims management, such as the greater use of sophisticated electronic transfer systems (paperless systems) and other "state of the art" technological improvements.

CHAPTER III. COMPETITION IN THE SELECTION OF MEDICARE CONTRACTORS

One way to address the concerns with the existing system is to introduce competition in the award of Medicare administrative contracts. The use of competition would base contractor selection on an assessment of bidder capabilities rather than on nomination by the provider community. Under a competitive procurement, HCFA would identify the work to be performed, solicit proposals from the contractor community and other potential bidders, and evaluate the proposals based on preestablished selection criteria. These criteria could include some combination of the contractor's performance on other contracts (experience), the adequacy and responsiveness of the bidder's plan to perform the required work (technical merit), and the proposed cost.

Competition could also be used in conjunction with a system of reimbursement based on the establishment of a fixed level of reimbursement rather than the reimbursement for all expenses incurred. This amount of reimbursement would be established at the time of the award of the contract. The contractor would receive this sum of money regardless of the costs incurred in the performance of contractor responsibilities. 1/

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1. Several variants of the total-sum, fixed-price contract could be used. The first--a fixed-price-per-claim contract--would permit (continued)

Alternatively, contractors could compete on the basis of their historical cost performance on other contracts, but continue to be reimbursed for their actual costs. Although this system would not make contractors financially liable for their management practices and decisions, it would introduce competition in the award of contracts, would award them to those contractors with demonstrated abilities to implement cost-effective management procedures, and would provide contractors with incentives to be efficient so that they could win future competitions.

The remainder of this chapter will examine the direct impact of the competitively awarded, fixed-price contract on administrative costs and then turn to the indirect effects on the quality and timeliness of services

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1. (continued)
contractors to bid without many of the contingency costs that they include to compensate them for large fluctuations in claims volumes. This contract form could be further modified to require contractors to bid varying unit costs based on the level of claims received. HCFA would issue work orders (called task orders) to the contractor as claims were received. If few claims are received, unit costs would be higher; if the volume of claims increased, unit costs would decrease reflecting the efficiencies of scale of the larger volume. Some suggest that contractors might be able to manipulate the volume of claims and thereby increase their reimbursement, however.

Another type of contract format--a fixed-price-per-beneficiary or a fixed-price-per-beneficiary-month--would reimburse contractors for the number of beneficiaries in the contract area. This contract format would eliminate the uncertainties resulting from variations in the number of beneficiaries. Contractors would be encouraged to implement procedures to reduce the volume of claims, such as increasing the number of services included on one claim, to reduce their own costs. These efficiencies could reduce total administrative costs for the federal government.

offered to the provider and beneficiary communities. This discussion will examine both the theoretical arguments and data from several demonstration projects that awarded Medicare administrative contracts through a competitive, fixed-price contract procedure. In Chapter IV, both the competitive fixed-price and the competitive cost-reimbursement contracts are discussed as alternatives to the existing system.

COMPETITION AND ADMINISTRATIVE SAVINGS

Competition appeared to reduce Medicare administrative costs in demonstration projects when the contract solicitations generated several bidders; when few bids were received, however, the administrative costs were increased relative to the previous cost-reimbursement contract. In all demonstration projects, the fixed-price contract increased administrative costs in a four-to-nine month transition period during which the existing cost-reimbursement contractor maintained ongoing claims processing activities and the fixed-price contractor simultaneously established the new managerial and technological systems in the contract area. After the initial year, however, contract administrative costs were, on average, between 15 and 20 percent lower than costs projected under the cost-reimbursement contract.